REPORT TO THE

JOINT LEGISLATIVE COMMISSION ON GOVERNMENT OPERATIONS

SENATE APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

FISCAL RESEARCH DIVISION

AND

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

OLMSTEAD REPORT

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December 1, 2007

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Olmstead Report
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The 1999 U.S. Supreme Court Olmstead v. L.C. & E.W. decision and State policy require provision of appropriate services to clients in the least restrictive and most appropriate environment. To accomplish this, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has implemented initiatives to transition patients from State psychiatric hospitals to the community or to other long-term care facilities as appropriate. The initiatives meet the following guiding principles:

1. Individuals shall be provided acute psychiatric care in non-State facilities when appropriate.
2. Individuals shall be provided acute psychiatric care in state facilities only when non-State facilities are unavailable.
3. Individuals shall receive evidence-based psychiatric services and care that are cost-efficient.
4. The State shall minimize cost shifting to other State and local facilities or institutions.

Olmstead Assessments. Olmstead Assessments began in the State hospitals in 2001. Assessments are completed with individuals who have been hospitalized 60 or more days with the goal of identifying the types of services and supports an individual will need when he/she transitions to the community. There are approximately 400 Assessments completed annually. The assessments incorporate the following:

- A Standardized Level of Care Assessment completed by hospital staff.
- Individual preferences are identified to guide the transition planning to the extent possible during standard treatment and in the Service Planning Meeting (see below).
- Service Planning Meetings which are typically attended by the individual, family/guardian (if appropriate), hospital treatment team, and staff from the Local Management Entity (LME)/contracted provider.
- Results of the Level of Care Assessment, clinical information and input from the individual and family/guardian are reviewed.
- A Service Plan is developed that includes information about the individual's needs and preferences in the community and identification of possible services. In aggregate, the information from the Service Plans can assist LMEs as they plan and develop community services.

Olmstead assessments are reviewed annually if an individual remains hospitalized.

As the individual is clinically ready to be discharged from the hospital to the community, the treatment team finalizes the discharge plan which incorporates information identified through the Olmstead Assessment. As with the Olmstead Assessment itself, the team that finalizes the discharge plan includes the patient and family/guardian, hospital treatment team and LME/provider representatives. Specific service providers or supports are identified that address the individual's needs are identified and referrals are made. Whenever possible, the primary provider of services meets with the individuals prior to discharge to begin to establish a rapport. At a minimum, the LME is required by contract to ensure that patients discharged from State hospitals have an intake appointment within 7 days of discharge. In instances where the preferred service is not available, the team finalizing the discharge plan must develop a plan that still addresses the individual's needs. For example, if an individual would benefit from an Assertive Community Treatment Team, but is returning to a rural area where ACTT does not exist, the discharge team may refer the individual to Community Support Team, medication management, and a Psychosocial Rehabilitation Program.

Recidivism Reviews. Recidivism reviews have been initiated at each State psychiatric hospital during the current fiscal year. The goal of the Recidivism Review process is to better assist those individuals with frequent State hospital admissions to remain in the community. The Recidivism Review teams identify patients who have frequent readmissions to the hospital and develop specific goals on the treatment plan to reduce those frequent readmissions. Hospital staffs collaborate with LME and/or provider representatives, as well as the patient and family/guardian, to address the issues leading to recidivism. The recidivism reviews typically identify patients who have numerous short term admissions of less than 60 days and therefore do not have an Olmstead Assessment completed. DMH/DD/SAS will monitor the on-going implementation of the Recidivism Review process and outcomes.

DMH/DD/SAS Activities. Ongoing chart reviews are conducted quarterly at each State psychiatric hospital to document discharge planning processes. Information from these reviews is shared with the hospitals to facilitate improvement in discharge planning and recidivism rates.

In addition, State Operated Services coordinates with the Local Management Entities (LMEs) regarding data from the hospitals showing recidivism of their catchment area consumers. Data can be pulled from the system on any time frame. The LMEs have indicated this is very helpful to them in identifying problem areas and improving practices.